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The Role of Maternal Postmigration Living Difficulties in Intergenerational Trauma Transmission Among Asylum-Seeker Mother–Child Dyads: Exploring Complex Posttraumatic Stress Disorder as a Mechanism

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Objective: Among forcibly displaced people, maternal trauma and stress have been implicated in poor child socioemotional outcomes via intergenerational trauma transmission. This study explored the role of maternal postmigration living difficulties (PMLD) in the pathway linking maternal trauma, trauma-related psychopathology, and child socioemotional outcomes among mother–child dyads seeking asylum in a high-risk urban setting. ***Method:*** Participants were East African (Eritrean) mothers (N = 127) of preschool-aged children seeking asylum in Israel. Using moderated mediation analysis, we tested whether and how PMLD may moderate the mediating role of current maternal *International Classification of Diseases, 11th revision* (*ICD-11*) posttraumatic stress disorder (PTSD) and complex posttraumatic stress disorder disturbances in self-organization (DSO) symptoms between past maternal trauma exposure and current postdisplacement child internalizing and externalizing difficulties. Children's direct exposure to adverse life experiences was controlled for. ***Results:*** Maternal PTSD symptoms mediated the association between past maternal trauma exposure and child internalizing difficulties, but not externalizing difficulties, across all levels of current maternal PMLD. However, maternal DSO symptoms mediated internalizing and externalizing child outcomes, but only among mothers reporting high levels of current PMLD. ***Conclusion:*** This study provides novel evidence that PMLD may amplify the toxicity of past maternal trauma exposure for poor child socioemotional outcomes via *ICD-11* DSO symptoms. The intergenerational transmission pathway via the narrower fear-based *ICD-11* PTSD, however, is independent of the degree of maternal PMLD. Findings suggest that policies designed to buffer intergenerational trauma transmission among forcibly displaced people may need to consider the toxicity of PMLD as well as enable mothers to heal from PTSD.

Clinical Impact Statement

This study highlights the risk for intergenerational trauma transmission when forcibly displaced mothers of preschool-aged children experience high levels of postmigration living difficulties (PMLD). Specifically, maternal disturbances in self-organization, a core feature of the *International Classification of Diseases, 11th revision,* complex posttraumatic stress disorder, represent a relevant intergenerational transfer mechanism when PMLD are high. For forcibly displaced mothers with complex posttraumatic stress disorder, the successful mitigation of intergenerational trauma transmission should include alleviation of PMLD, above and beyond providing mental health support to heal and recover from stress-related mental health disorders.

Keywords: complex posttraumatic stress disorder, disturbances in self-organization, refugees and asylum-seekers, intergenerational trauma transmission, postmigration living difficulties

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The data reported in this article were collected as part of a larger data

continued

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There is a fast-growing number of forcibly displaced people (FDP) seeking sanctuary following trauma and loss associated with conflict, persecution, and natural disasters (United Nations High Commissioner for Refugees [UNHCR], 2023). Worse yet, increasingly unstable high-risk postmigration settings are often characterized by a range of postmigration living difficulties (PMLD), such as socioeconomic stressors (e.g., financial and housing insecurity), social and interpersonal stressors (e.g., separation from family, perceived discrimination), and stressors related to immigration policies (e.g., detention, temporary visa; Hynie, 2018; Li et al., 2016). There is strong evidence that PMLD can directly contribute to, as well as amplify, the toxicity of past trauma exposure for posttraumatic stress disorder (PTSD) and related conditions postdisplacement (e.g., Chen et al., 2017; Miller & Rasmussen, 2017). PMLD have thus been described as a, if not the central, social determinant of trauma sequelae postdisplacement (Hou et al., 2020; Hynie, 2018).

Importantly, forced displacement is not only strongly associated with poor individual trauma- and stress-related mental health outcomes but also with poor multisystemic outcomes for forcibly displaced families and children (Flanagan et al., 2020). Yet, despite growing evidence implicating trauma and PTSD postdisplacement among adult FDP in poor socioemotional developmental outcomes in their children, much less scientific attention has focused on the role of PMLD in these pathways of intergenerational transmission (Sangalang & Vang, 2017). Indeed, a recent qualitative study among 27 families seeking asylum in Sweden documented that parents perceive PMLD to negatively affect their mental health and, thereby, their ability to parent sensitively (Hedstrom et al., 2021). A second qualitative study among 30 refugee families from the Middle East residing in Denmark documented that a majority of refugee and asylum-seeking parents reported that everyday stressors had a greater impact on the well-being of their children than their past trauma exposure (Dalgaard & Montgomery, 2017). Third, a systematic review of studies on migrant and refugee parents documented that experiencing daily PMLD was associated with reduced parental self-efficacy (Boruszak-Kiziukiewicz & Kmita, 2020). However, strong quantitative or experimental evidence implicating parental PMLD in intergenerational transmission of posttraumatic stress is limited, as is the study of the mechanisms through which such intergenerational effects may emerge.

We argue here that theory and extant findings implicate complex PTSD (CPTSD) among FDP parents in the sociocontextualized developmental mechanism(s) that contribute to poor child socioemotional outcomes. CPTSD is a new diagnosis, introduced in the 11th revision of the *International Classification of Diseases* (*ICD-11*; World Health Organisation [WHO], 2019). It is defined by the presence of classic PTSD symptoms (reexperiencing the traumatic event, avoidance of trauma reminders, and heightened sense of threat) as well as disturbances in self-organization (DSO), characterized by affective dysregulation, a negative self-concept, and disturbed relationships (Maercker et al., 2022; WHO, 2019). By interfering with parental trauma recovery and adaptation to postmigration, PMLD may amplify the toxicity of past trauma exposure for CPTSD among refugee parents (Liddell et al., 2019; Schiess-Jokanovic et al., 2021; *ICD-11*; WHO, 2019). Prevalence of CPTSD may be as high as 50.9% in high-risk postdisplacement settings (de Silva et al., 2021), and past trauma exposure may be more specifically associated with *ICD-11* PTSD symptoms (i.e., "classic" fear reactions related to trauma), whereas PMLD may be more specifically associated with the broader CPTSD DSO symptoms (Hecker et al., 2018). Moreover, parental CPTSD may be particularly detrimental to parenting and parent–child attachment and relationships. For example, individuals with CPTSD per definition struggle to be emotionally close to significant others (WHO, 2019). It has been shown in a British clinical sample of trauma survivors that CPTSD is associated with higher levels of attachment anxiety and avoidance than those with PTSD (Karatzias et al., 2018). Additionally, emotional dysregulation includes outbursts of anger, which might contribute to violence and harsh parenting styles that affect children's socioemotional problems (Bryant et al., 2018; Sim et al., 2018).

These core features of CPTSD DSO (i.e., affective dysregulation, negative self-concept, enduring disturbances in relationships) have been implicated in child internalizing symptoms (e.g., excessive worry or anxiety, frequent tearfulness or sadness, social withdrawal

collection (at 1 point in time). Findings from the data collection have been reported in one other article (Bachem et al., 2024). It compared the severity of internalizing and externalizing child outcomes when mothers had probable complex posttraumatic stress disorder, posttraumatic stress disorder, depression only, or healthy mothers (without complex posttraumatic stress disorder, posttraumatic stress disorder, or depression), using multivariate analyses of variance. No evaluation of the role of postmigration living difficulties in intergenerational trauma transmission was made in the previous article. No other potential mechanisms of trauma transmission were explored. The authors have no conflicts of interest to disclose.

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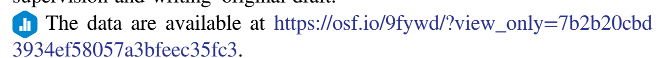
The data are available at https://osf.io/9fywd/?view_only=7b2b20cbd3934ef58057a3bfeec35fc3.

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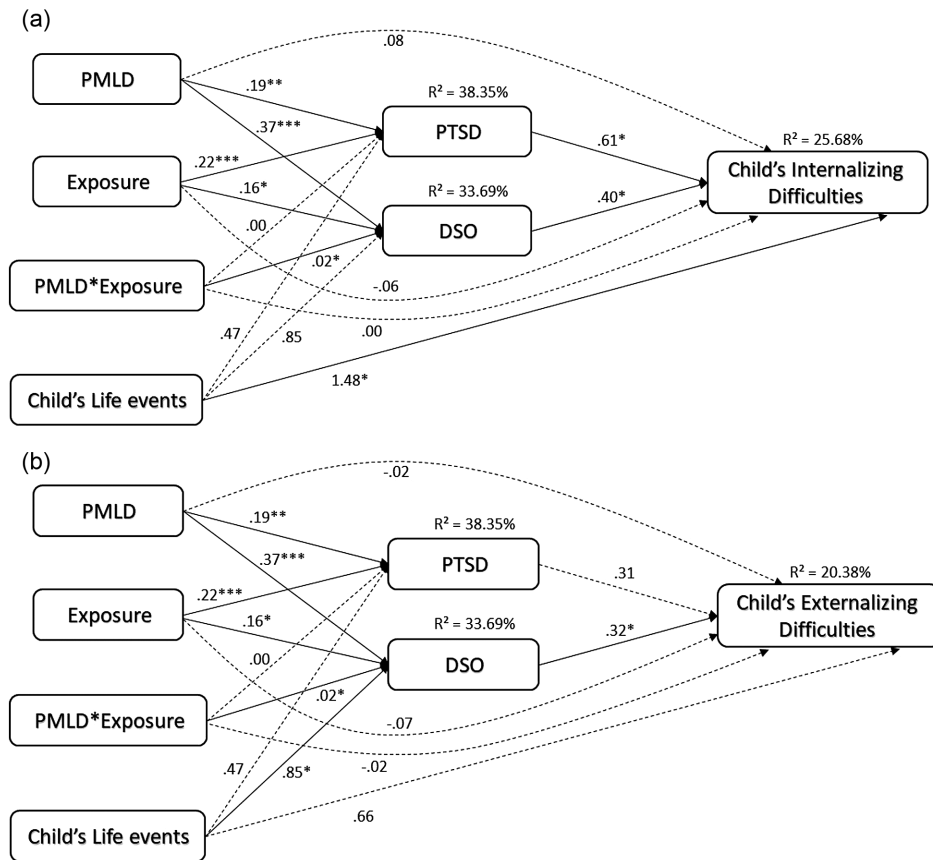
or isolation; Pinquart, 2017b) and externalizing symptoms (e.g., aggression, defiance, and hyperactivity; Pinquart, 2017a). Indeed, among asylum-seekers living in a high-risk urban postdisplacement setting, maternal CPTSD and comorbid depression were strongly associated with elevated internalizing and externalizing child outcomes, above and beyond direct adverse childhood experiences (Bachem et al., 2024). Thus, in so far as PMLD may amplify the toxicity of past maternal trauma exposure associated with forced displacement and thereby the risk for CPTSD, it may also elevate the risk for intergenerational trauma transmission to children of forcibly displaced mothers.

Therefore, in the present study, we aimed to test whether the narrower fear-based *ICD-11* PTSD and/or the broader CPTSD DSO symptoms mediate the effect of past maternal trauma exposure on child socioemotional developmental outcomes, particularly among asylum-seeking mothers exposed to high levels of PMLD. Thus, among 127 asylum-seeking mother–child dyads living in a high-risk urban postdisplacement setting (see Bachem et al., 2024, for details), we tested the theorized moderated mediation pathway linking past maternal trauma (predictor), current maternal PMLD (moderator), maternal PTSD and CPTSD DSO symptoms (mediators), and poor child socioemotional outcomes postdisplacement (dependent variables). Specifically, we first tested whether current maternal PMLD moderated the association between past maternal trauma exposure and current maternal *ICD-11* PTSD and CPTSD DSO symptoms postdisplacement (Figure 1). Second, we tested whether maternal *ICD-11* PTSD and CPTSD DSO symptoms mediated the association between past maternal trauma exposure and current child socioemotional problems, and critically, whether maternal PMLD moderated this mediated pathway. We hypothesized that, above and beyond any direct effect of past maternal trauma exposure and/or PMLD on maternal mental health and child socioemotional outcomes, elevated PMLD would also interact with and thereby amplify the toxicity of past trauma exposure ("double jeopardy" of exposure) for maternal PTSD and CPTSD DSO symptoms and thereby for poor child socioemotional outcomes. To rigorously isolate the role of intergenerational transmission in this developmental pathway of risk for poor child socioemotional outcomes from direct adverse childhood experiences postmigration, we tested the hypothesized transmission effects above and beyond adverse

Figure 1

Moderated Mediation Model



Note. (a) Children's internalizing difficulties and (b) children's externalizing difficulties. Moderated mediation model on the effect of postmigration living difficulties (PMLD), trauma exposure and their interaction regarding maternal posttraumatic stress disorder (PTSD), and disturbances in self-organization (DSO).
* $p < .05$. ** $p < .01$. *** $p < .001$.

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life events that children experienced directly postdisplacement (e.g., severe accidents, death of close family members, domestic violence).

Method

Participants

The present study focused on a high-risk sample of asylum-seeking Eritrean mothers and their preschool-aged children in Israel. While crossing through the Sinai, many migrants fell prey to human traffickers, many of whom were victims of torture during displacement and thus arrived in Israel following significant and multiple traumatic stressors (Nakash et al., 2017). Moreover, state authorities have denied this population stable residential status, and consequently, less than 0.5% have received refugee status. In this way, government policies have deprived asylum-seekers of social security benefits, health insurance, and other social services and contribute to a highly unstable postmigration setting characterized by extensive PMLD (Aid Organization for Refugees and Asylum Seekers in Israel, 2022; Nakash et al., 2017).

Procedure

Inclusion criteria for this study were being a mother of a preschool-aged child seeking asylum in Israel, of Eritrean origin, and being able to answer questions in Tigrinya with the help of Eritrean research assistants. Exclusion criteria were suffering from acute psychosis or suicidality. Study participation was voluntary and could be terminated at any time. The study was approved by the ethics committee of Tel Aviv University. Data were collected from May to August 2019 in Tel Aviv, Israel. Recruitment was conducted in collaboration with a local non governmental organisation ("unitaf"; https://www.unitaf.org), which offers nurseries, daycares, and after-school programs for refugee and migrant children in several locations in south Tel Aviv. The centers are run in the national language, Hebrew. Mothers were approached and informed about the study as they picked up their children from daycare. Data were collected by a PhD-level psychologist (RB) and two trained Eritrean research assistants who provided standardized instruction and explanation or administered the questionnaire as a structured interview if participants were illiterate. Informed consent forms and study materials were presented in Tigrinya and English. Mothers provided information about themselves and the oldest of their preschool-aged children. Completing the questionnaire with the help of a research assistant took an average of 2.5 hr, and participants were compensated with 120 NIS (approximately $33).

Participants

The sample consisted of 127 mothers (M = 28.47, SD = 3.95, range = 19–42 years of age). In total, 95.3% were born in Eritrea, and 4.7% were Tigrinya-speaking persons born in other countries such as Sudan. Whereas the majority were married (84.8%), some were separated or divorced (12.0%), never married (2.4%), or widowed (0.8%). Participants had on average 8.2 (SD = 3.03) years of education and were working full-time (40.8%), part-time (34.9%), as day workers (work varies every week; 17.3%), or not employed (14.4%). In a previous analysis from this parent study (Bachem et al., 2024), 26.0% of mothers fulfilled the criteria for probable *ICD-11* PTSD (PTSD without DSO), and an additional 23.6% fulfilled the criteria for probable *ICD-11* CPTSD (PTSD with DSO). Comorbidity with probable depression was high (48.5% among mothers with PTSD and 94.5% among mothers with CPTSD). Mothers had M = 2.56 (SD = 1.04) children, who were M = 2.76 (SD = 1.17) years old and of whom n = 63 (51.2%) were girls. All children referred to in this study were born in the postmigration context in Israel.

Measures

Translation

Translation and Pilot Testing: The measures were translated from English to Tigrinya and back-translated for accuracy. Their intelligibility was established in a pilot focus group with three Eritrean women of the target community.

Trauma Exposure

Lifetime exposure to potentially traumatizing events was assessed using the 17-item trauma checklist from the Harvard Trauma Questionnaire (Mollica et al., 1992). The checklist rates trauma exposure on four levels (1 = not experienced; 2 = heard about; 3 = witnessed; 4 = experienced). A sum score of the number of traumatic event types was computed, with a possible range of 17–68.

PMLD

The PMLD Scale (Silove et al., 1997) is a self-reported measure of current postmigration stressors. A nine-item adapted version of the PMLD scale covering areas such as communication difficulties, family separation, financial issues, and access to services was used. Items were rated on a 5-point Likert scale (1 = *not a problem* to 5 = *very serious problem*; possible range = 9–45), and a sum score was used for data analysis. The Cronbach's α coefficient was .859 in the current sample, similar to or stronger than previous studies (Oren-Schwartz et al., 2023).

ICD-11 CPSD: PTSD and DSO Symptoms

The International Trauma Questionnaire (Cloitre et al., 2018) is a screening scale to assess *ICD-11* PTSD and CPTSD DSO symptoms. Six PTSD symptoms (reexperiencing, avoidance of trauma reminders, heightened sense of threat; two items each) and six DSO symptoms (affective dysregulation, negative self-concept, disturbances in relationships; two items each) were rated on a 5-point Likert scale (0 = *not at all* to 4 = *very strong*) and summed up separately for data analysis. The International Trauma Questionnaire demonstrated good reliability in diverse refugee populations (e.g., Hyland et al., 2018; Vallières et al., 2018). The internal consistency in this study was satisfactory (Cronbach's α = .860) for PTSD and excellent (Cronbach's α = .940) for DSO.

Child Mental and Behavioral Difficulties

The 100-item Child Behavior Checklist (CBCL) for ages 1.5–5 years (Achenbach & Rescorla, 2000) was used to assess social–emotional and behavioral problems in preschoolers. The CBCL is a

parent-report measure of children's symptoms. Syndrome scales included internalizing and externalizing symptoms, rated on a 3-point scale ranging from 0 (*not true as far as you know*) to 2 (*very true or often true*) and summed up in the present research. Internalizing symptoms include the following subscales: emotionally reactive, anxious/depressed, somatic complaints, withdrawal, and sleep problems; externalizing symptoms include the following subscales: attention problems and aggressive behavior. The CBCL demonstrated high internal consistency in this study (Cronbach's α of CBCL internalizing and externalizing difficulties were .942 and .971, respectively).

Children's Adverse Life Events

Adverse experiences were assessed using the Traumatic Events Screening Inventory–Parent Report (Ippen et al., 2002), which includes 12 items covering various potentially traumatic events experienced by children aged birth to 6 years. Items included 12 adverse experiences assessed via a dichotomous format (0 = *not experienced*; 1 = *experienced*): death in the family or someone close to the child, severe accident, hospitalization of the child or a close family member, separation from parents, depression of a close family member, physical abuse, emotional abuse, sexual abuse, arrest or imprisonment of family member, alcohol or drug addiction of close family member, exposure to fierce quarrels or domestic violence, as well as an open question of any other significant child experience.

Data Analysis

Data were analyzed with IBM SPSS Statistics Version 25.0. Little's missing completely at random test revealed that the data were missing completely at random, $\chi^2(27) = 38.00$, $p = .078$, and thereby modeled using estimation maximization (EM). First, bivariate Pearson correlations were calculated between PMLD and other study variables. Second, the proposed moderated effects were examined using the Process Macro for SPSS (Hayes, 2013), applying Model 1 with 5,000 bias-corrected bootstrap samples. The proposed moderated mediation model was tested using the Process Macro for SPSS (Hayes, 2013), applying Model 8 with 5,000 bias-corrected bootstrap samples, with all variables mean-centered. A two-way interaction was examined between PMLD and exposure on the indirect effect with the interaction that was specifically tested on the path between PMLD/exposure and the mediating variables, *ICD-11* PTSD and DSO. Individuals scoring 1 *SD* below the mean were categorized as having low levels of PMLD, while those scoring 1 *SD* above the mean were categorized as having high levels of PMLD. A p value of .05 was set as the critical level for statistical significance (for the analysis of indirect effects, if the 95% confidence interval includes 0, then the indirect effect is not significant at the .05 level; if 0 is not in the interval, then the indirect effect is statistically significant at the .05 level; Hayes, 2013).

Results

Descriptive Results

Trauma Exposure

Participants reported having witnessed or experienced on average 8.74 (SD = 4.24, range = 0–16) different types of potentially traumatizing events. The most prevalent potentially traumatic event was lack of food or water, experienced by n = 118 (93.7%). However, interpersonal trauma, such as torture (n = 70, 55.1%) or sexual abuse (n = 23, 18.1%), was also frequently indicated.

PMLD

Mothers reported an average of M = 6.17 (SD = 2.56) types of PMLD that they experienced as a serious or very serious problem. The most frequent type of PMLD was fear of deportation, rated as a serious or very serious problem by n = 115 (91.3%), followed by poor access to educational services (n = 111, 88.1%), and separation from family members (n = 109, 86.5%). The least frequently endorsed PMLD was communication difficulties, experienced as a severe or very severe problem by n = 48 mothers (38.1%). More information on the prevalence of PMLD is presented in Table 1.

Correlations

Current maternal PMLD were positively moderately correlated with PTSD ($r = .48^{***}$, $p < .001$) and DSO ($r = .48$, $p < .001$), past maternal trauma exposure ($r = .44$, $p = .001$), and child internalizing ($r = .31$, $p < .001$) and externalizing ($r = .27^{**}$, $p = .005$) difficulties (see Bachem et al., 2024, for additional correlations).

Table 1
Prevalence of Postmigration Living Difficulties (N = 127)

Area of postmigration living difficulty	No problem		Small or moderate problem		Serious or very serious problem	
	N	%	*N*	%	*N*	%
Communication difficulties	13	10.3	65	51.6	48	38.1
Separation from family	9	7.1	8	6.3	109	86.5
Unable to find job/bad work conditions	17	13.5	36	28.6	73	57.9
Conflict with immigration officials	37	29.4	14	11.1	75	59.5
Fears of being sent home	8	6.3	3	2.4	115	91.3
Not enough money for food, hygiene products, rent/utilities, or clothes	15	11.9	32	25.4	79	62.7
Loneliness and boredom	17	13.5	35	27.8	74	58.7
Worries about no regular place to sleep	18	14.3	14	11.1	94	74.6
Poor access to educational services	7	5.6	8	6.3	111	88.1

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PMLD as Moderator of Past Maternal Trauma Exposure and Current PTSD/CPTSD DSO

For *ICD-11* PTSD symptoms, the model was significant, $F(3, 108) = 26.38$, $p < .001$, $R^2 = 42.23\%$. Greater trauma exposure ($b = .20$, $SE = .04$, $t = 4.53$, $p < .001$) and PMLD ($b = .27$, $SE = .06$, $t = 4.11$, $p < .001$) each contributed to higher levels of *ICD-11* PTSD. The interaction term of maternal Past Trauma Exposure × PMLD for *ICD-11* PTSD was not significant ($b = .00$, $SE = .01$, $t = .03$, $p = .98$). Indeed, in both high ($b = .20$, $SE = .06$, $t = 3.31$, $p = .001$) and low ($b = .20$, $SE = .06$, $t = 3.37$, $p = .001$) levels of PMLD, trauma exposure significantly contributed to elevated *ICD-11* PTSD symptom severity.

For *ICD-11* CPTSD DSO symptoms, the model was also significant, $F(3, 107) = 17.74$, $p < .001$, $R^2 = 33.22\%$. Likewise, greater trauma exposure ($b = .17$, $SE = .06$, $t = 2.71$, $p = .010$) and PMLD ($b = .44$, $SE = .09$, $t = 4.77$, $p < .001$) contributed to higher levels of CPTSD DSO. In contrast, the interaction term of Trauma Exposure × PMLD for *ICD-11* CPTSD DSO was significant ($b = .01$, $SE = .01$, $t = 2.03$, $p = .045$). Specifically, greater trauma exposure was associated with elevated *ICD-11* CPTSD DSO symptom severity in the event of high levels of PMLD ($b = .29$, $SE = .09$, $t = 3.32$, $p = .001$) but not in the event of low levels of PMLD ($b = .05$, $SE = .08$, $t = .63$, $p = .531$).

PMLD as Moderator of Mediation Between Maternal Trauma Exposure and Child Internalizing Difficulties via PTSD/CPTSD DSO

The overall moderated mediation model predicting child internalizing difficulties was significant, $F(6, 120) = 6.91$, $p < .001$, $R^2 = 25.68\%$. Direct associations between past maternal trauma exposure and current PMLD for current child internalizing difficulties were not significant. Testing the paths from the mediators to the dependent variable (child internalizing difficulties) showed both PTSD and CPTSD DSO were significantly positively associated with greater child internalizing difficulties. Importantly, the hypothesized mechanism of moderated mediation of child internalizing difficulties was significant.

The indirect effect via *ICD-11* PTSD was not significant ($b = .0000$, $SE = .0030$, 95% CI [−.0070, .0056]). In contrast, the indirect effect via CPTSD DSO was significant ($b = .0058$, $SE = .0039$, 95% CI [.0007, .0161]). At high levels of maternal PMLD, the association between maternal past trauma exposure and child internalizing difficulties via maternal CPTSD DSO was significant ($b = .11$, $SE = .07$, 95% CI [.0147, .2657]), whereas at low levels of PMLD, this indirect association was not significant ($b = .02$, $SE = .07$, 95% CI [−.0231, .1105]). In contrast, at high ($b = .13$, $SE = .07$, 95% CI [.0253, .3107]) and low ($b = .13$, $SE = .07$, 95% CI [.0270, .3091]) levels of PMLD, the association between maternal past trauma exposure and child internalizing difficulties via PTSD was significant. In other words, mediation of maternal trauma exposure and child internalizing difficulties via CPTSD DSO was dependent on elevated levels of PMLD, whereas mediation via PTSD was observed across levels of PMLD. These effects were observed above and beyond child adverse exposure.

PMLD as Moderator of Mediation Between Maternal Trauma Exposure and Child Externalizing Difficulties via PTSD/CPTSD DSO

The overall moderated mediation model predicting child externalizing difficulties was significant, $F(6, 120) = 5.12$, $p < .001$, $R^2 = 20.38\%$. Direct associations between maternal past trauma exposure and current PMLD and child externalizing difficulties were not significant. PTSD was not associated with child externalizing difficulties. Testing the mediation paths showed that Path A, between trauma exposure and PMLD on the one hand, and high levels of both PTSD and CPTSD DSO on the other hand, were significant. Examination of paths from CPTSD DSO to child externalizing difficulties showed a positive and significant association. However, the association between PTSD and child externalizing difficulties was null.

Most importantly, probing the interaction showed support for the hypothesized mechanism of moderated mediation mechanism of child externalizing difficulties. Testing the indirect effect of the highest-order interaction showed that the indirect effect via *ICD-11* PTSD was not significant ($b = .0000$, $SE = .0016$, 95% CI [−.0043, .0031]), although it was marginally significant via CPTSD DSO ($b = .0046$, $SE = .0034$, 95% CI [.0001, .0131]). At high levels of PMLD, the association between maternal past trauma exposure and child externalizing difficulties via CPTSD DSO was significant ($b = .09$, $SE = .05$, 95% CI [.0090, .2221]), while at low levels of PMLD, this indirect association was not significant ($b = .02$, $SE = .02$, 95% CI [−.0179, .0818]). However, both at high ($b = .07$, $SE = .05$, 95% CI [−.0056, .2034]) and low ($b = .07$, $SE = .06$, 95% CI [−.0097, .1826]) levels of PMLD, the association between maternal trauma exposure and child externalizing difficulties via PTSD was null. In other words, mediation of maternal past trauma exposure and current child externalizing difficulties via *ICD-11* CPTSD DSO was dependent on high PMLD. However, *ICD-11* PTSD did not mediate this pathway regardless of current maternal PMLD. The moderated effect of PMLD on the mediation via CPTSD DSO was observed above and beyond child exposure to adversity.

Discussion

To advance understanding of the mechanisms in intergenerational transmission of trauma among FDP, we sought to understand the role of PMLD in the developmental pathway linking maternal trauma, trauma-related psychopathology, and child socioemotional outcomes postmigration. Importantly, this study was conducted among a large population of FDP, asylum-seekers from East Africa, living in what is now the most common, yet understudied, postmigration settings—unstable high-risk urban cities (UNHCR, 2023). The present findings may therefore inform our understanding of the growing mental health crisis of forced displacement broadly and its intergenerational implications more specifically.

As predicted, maternal CPTSD DSO symptoms mediated the association between past maternal trauma exposure and child internalizing and externalizing symptoms, but only among mothers experiencing high levels of PMLD. Yet, in the same moderated mediation model, the narrower *ICD-11* fear-based PTSD symptoms also mediated the same developmental pathway between past maternal trauma exposure and child internalizing, but not

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externalizing symptoms, and this mediation was observed independent from maternal levels of PMLD. Thus, whereas CPTSD DSO symptoms were associated with a greater range of poor child socioemotional outcomes than were the narrower fear-based PTSD symptoms, the intergenerational transmission associated with CPTSD DSO was more contextually dependent on exposure to PMLD. Finally, these effects were observed above and beyond direct exposure to adverse childhood experiences and therefore more readily attributed to intergenerational trauma transmission.

Given the strong link between PMLD and PTSD that has been previously documented (e.g., Hou et al., 2020), the present findings may seem surprising. Yet most of these earlier studies did not distinguish between CPTSD and narrower fear-based PTSD symptoms, per the *ICD-11*, but more commonly operationalized PTSD per the *Diagnostic and Statistical Manual of Mental Disorders*. Accordingly, it is difficult to know whether and to what degree previously observed associations for PTSD among FDP may have been accounted for primarily by CPTSD DSO symptoms rather than the fear-based element of PTSD symptomatology. Indeed, the present findings align with Hecker et al. (2018), who found that in a sample of refugees from multiple origin countries living in Switzerland, PMLD were only associated with CPTSD DSO symptoms but not PTSD symptoms. Similarly, in a nonrefugee context, daily hassles were shown to undermine a central feature of DSO, emotion regulation difficulties (Tinajero et al., 2020). Thus, *ICD-11* PTSD symptoms, closely associated with memories of the traumatic event, may interact less with nontraumatic difficulties of everyday life, such as PMLD.

In the present study, maternal CPTSD DSO were associated with externalizing and internalizing child outcomes, but only when PMLD were high, whereas the toxicity of maternal PTSD was independent of PMLD and limited to child internalizing symptoms. Regarding the contextual dependence of CPTSD DSO on exposure to PMLD, a vulnerability–stress perspective (Lazarus, 1991) may provide a viable explanation. When PMLD-related stress is low, mothers may possess sufficient resources to compensate for DSO-related deficits in interactions with their children, such as anger outbursts, harsh parenting, or decreased emotional accessibility. However, when hard-pressed by migration-specific daily hardships, mothers may no longer have this capacity for self-regulation. A study with trauma-exposed participants from Scotland indeed showed that CPTSD DSO severity was predicted by nontraumatic stressful life events, such as problems associated with relationships, work, or health (Karatzias et al., 2021). In contrast to CPTSD DSO, it could be postulated that maternal control of fear-based PTSD symptoms and their impact, for example, in interactions with their children, may be less viable as these symptoms are often conditioned fear reactions in response or closely tied to a confrontation with trauma triggers (Maercker et al., 2022).

The wider impact of CPTSD DSO symptoms on a greater range of poor child socioemotional outcomes compared to PTSD symptoms may be related to the fact that CPTSD DSO represent how people *typically* feel, think, and relate to others (WHO, 2019). DSO symptoms are relevant across a variety of situations and circumstances and are not primarily in response to traumatic stimuli. Indeed, maternal DSO symptoms are strongly implicated in interpersonal processes, such as higher levels of attachment insecurities (Karatzias et al., 2018), and affect dysregulation in interactions with significant others (e.g., outbursts of anger). Thus, such CPTSD DSO symptoms, when aggravated by high PMLD, may well contribute to a range of negative interactions with children that are likely to contribute to both internalizing as well as externalizing symptoms (Pinquart, 2017a, 2017b). In contrast, PTSD symptoms, such as avoidance of trauma-related stimuli and reexperiencing of trauma-related memories and emotions, may often be more internally directed private experiences, with potentially less contribution to the type of chaotic interactions (e.g., harsh control, psychological control) that may drive child externalizing symptoms (Pinquart, 2017a). An important next step in understanding these developmental pathways is to examine the role of parenting styles and parent–child interactions among FDP struggling with CPTSD DSO and PTSD symptomatology (Bryant et al., 2018).

This study has several limitations that may be important to guide future studies. First, the use of self-report questionnaires may be associated with the possible over- or underreporting of mental health issues. However, our previous work with this population (AB) suggests that self-reporting is a more culturally and clinically sensitive approach to the measurement of highly stigmatized mental health issues than interviews. Second, maternal reports of their own symptoms and their child's difficulties may be biased due to shared method and informant variance. Multi-informant assessment, however, was not feasible in the context of this community-embedded high-risk postmigration setting. Third, the cross-sectional nature of the data does not permit causal interpretation of the findings. Prospective and intervention designs are needed to examine the theorized causality leading to poor child outcomes postmigration. Fourth, the findings of the present study may not be generalizable to families with older children who may be less dependent on their primary caregivers and better able to gain social support from their peers or other adults. Finally, findings may be limited to the present population of asylum-seekers and postmigration settings. To determine the generalizability of the present findings, future studies should broaden the study of the mechanisms of intergenerational trauma transmission to other FDP and postdisplacement settings. In light of the pervasiveness of PMLD in increasingly common unstable high-risk postdisplacement settings and the projected rapid growth of forced displacement, understanding these candidate risk mechanisms for poor child socioemotional outcomes postdisplacement is critically important.

The findings of this study may have important implications for better understanding the developmental pathways to poor outcomes among FDP children, for informing prevention of intergenerational trauma transmission in postmigration settings, and for policy in host-nation communities. In terms of advancing understanding of the developmental pathways to poor socioemotional outcomes among children born postdisplacement, findings suggest that PMLD may amplify detrimental effects of past maternal trauma exposure on poor socioemotional outcomes in children, specifically through the manifestation of *ICD-11* CPTSD DSO symptoms. Second, findings may indicate that clinical interventions aimed to buffer intergenerational trauma transmission and improve child socioemotional outcomes may need to be tailored to the specific profiles of trauma sequelae and postmigration stressors among asylum-seeking mothers. For mothers with CPTSD DSO symptoms, interventions should address both the toxicity of PMLD and the effects of maternal CPTSD symptoms. By targeting these dual factors, interventions can potentially mitigate the negative impact on child outcomes. Therapy concepts aimed at complex traumatized individuals typically follow a staged or modular approach that combines non-trauma-focused techniques (addressing DSO symptoms) and trauma-focused techniques (addressing PTSD symptoms;

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Cloitre et al., 2012; Karatzias & Cloitre, 2019). Consequently, reduced DSO symptoms may enable improved interpersonal competencies and emotion regulation skills (Cloitre et al., 2011) and thereby more successful coping with challenges related to PMLD (Schiess-Jokanovic et al., 2021). It would be promising to examine the potential effectiveness of such phase-based interventions for refugee populations. On the other hand, for mothers with narrower fear-based PTSD symptoms, therapeutic interventions could focus on attenuating the direct effects of maternal PTSD symptoms to protect or improve child internalizing outcomes.

Policymakers also have an important role in establishing policies and programs that reduce poor intergenerational outcomes and thereby resettlement outcomes. Ensuring equity and implementing policies and programs that limit unnecessary PMLD seem central. This may be done in a range of ways, from various forms of access to resources, opportunities, and care, as well as by reducing xenophobia and maltreatment. Doing so would not only improve maternal mental health outcomes but, in turn, buffer the potential long-term societal costs (e.g., welfare, health care) on host-nation communities tied to large-scale intergenerational trauma transmission. Not to mention that such a policy is the humane thing to do in response to the global human rights and mental health crisis of forced displacement. Indeed, poor child socioemotional outcomes postdisplacement are associated with elevated risk for peer victimization (van Lier et al., 2012), academic underachievement (Shi & Ettekal, 2021), and developmental trajectories associated with poor mental and physical health throughout the life course (Arslan et al., 2021; Jamnik & DiLalla, 2019; Mesman et al., 2001).

In conclusion, this study provides valuable insights into the complex relationships between maternal trauma, PMLD, and child socioemotional outcomes in FDP families. By recognizing the distinct mechanisms of intergenerational trauma transmission, researchers, practitioners, and policymakers can develop personalized interventions to promote positive child outcomes and support the healing and recovery of forcibly displaced mothers in the postmigration setting. Indeed, few global sustainable developmental goals are as consequential as the successful mitigation of intergenerational transmission of trauma and stress among FDP (Flanagan et al., 2020; Sangalang & Vang, 2017).

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